



Vision Service Plan (VSP)

VSP 2021

Employee Benefits

PO Box 810 Montpelier VT 05601 229-2231

Offered exclusively to members of participating Chambers of Commerce

VSP only Employer Enrollment Agreement

Business Name/EmployerName: _____

Employer Contact Name: _____

Billing Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Phone #: (____) _____

Contact E-Mail Address: _____

Town in which Business is Physically Located: _____

Proposed Effective Date of Coverage: _____

I hereby certify by my signature that my firm is a member in good standing with the

_____ Chamber of Commerce. I understand that my firm's ability

to obtain and maintain this coverage is predicated on my firm's maintaining its membership with the Chamber.

Insurance Agency: _____

Insurance Agent Name: _____

Authorized signature of Employer: _____

Title: _____ **Date:** _____

Employee: _____ \$12.00

Employee + Spouse or child: _____ \$19.00

Employee + Family: _____ \$29.00